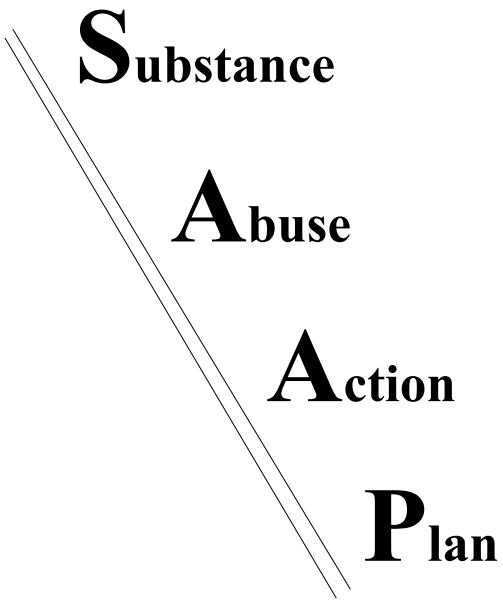
LINCOLN - LANCASTER COUNTY



FY 2002-2005

Completed in Conjunction With the
Community Services Implementation Project
Behavioral Health Coalition

April 1, 2002

Accepted and Supported as a Working Document:

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FOREWORD

The U.S. Office of Justice identifies substance abuse as one of the most pervasive problems facing our nation, costing over $275 billion in health care costs, lost productivity, related crime, and other social costs, and contributing to over 130,000 deaths each year. (1)

The abuse of alcohol, tobacco and illicit drugs places an enormous burden on this country. In fact, there are more deaths, illnesses, and disabilities from substance abuse than from any other preventable health condition. The economic costs of substance abuse are staggering. The treatment of medical related problems, family violence, child abuse and neglect, loss of work productivity, and auto related accidents all have social and financial costs to pay.

Lancaster County like the rest of this country, has a substance abuse problem and it's an expensive one. Federal, state, and local dollars totaling $6.4 million, fund substantial projects like juvenile and adult drug courts, agencies like Cornhusker Place and CenterPointe, and transitional housing programs like Houses of Hope. Of this amount, $1.5 million is all local taxpayer dollars (see attachment #2A).

The cost of a motor vehicle crash includes wage and productivity losses, medical expenses, administrative expenses, motor vehicle damage, and employer costs. In year 2001, of 276 Nebraska car crash fatalities, 98 (35%) were alcohol-related. The National Safety Council estimates the total cost per fatality was $980,000 x 98 = $96,040,000. That of course, does not add in the value of a life (see attachment #2 B&C).

States generally leverage their dollars by seeking additional private foundation or federal funding to address substance abuse. However, Nebraska has failed to attempt to seek such funds. In fact, until the recent tobacco settlement, Nebraska ranked 47th in the country in the amount we spent on this number one health problem.

In Lancaster County, NE., we have embraced a full scale community human service planning process known as CSIP (Community Services Implementation Plan). Under this plan, there are seven areas of identified high priority needs including Behavioral Health. The Behavioral Health Coalition has defined behavioral health care as that which provides prevention, intervention, and treatment services in the areas of mental health, substance abuse, developmental disabilities and sexual health. Guidelines of the Coalition indicated behavioral health should be individualized, holistic, culturally competent and may include on-going care, support and non-traditional services.

With that in mind, the community established a more focused SAAT - Substance Abuse Action Team which very specifically defined a narrower goal and specific strategies within three major areas of foci - prevention, treatment, and criminal justice. Over 200 people participated in various phases of the action planning. The following action plan is a culmination of those efforts. The plan is intended to take three years to fully evolve. Teams to review, implement and monitor the action strategies are in place. The strategies themselves are or shall be based on best practice/science-based models adaptable to Lincoln, Lancaster County. This SAAT implementation plan will become an integrated part of the over-all CSIP implementation process community-wide.

(1) RW Johnson Foundation, Substance Abuse, 2/01 p. 6

Executive Summary

During the early stages of the comprehensive substance abuse planning process we determined a vision for a healthy community. We agreed **"We share the desire to have a community free from substance abuse. A vision of reality is to have a community where strong prevention measures prevail and where all people have access to substance abuse treatment."** We developed a working definition for substance abuse: **"Substance abuse will include alcohol, prescribed drugs, street drugs, and gateway drugs such as tobacco, whose use can have an intended or unintended negative impact on an individual or family life."**

Three major goals need to be addressed. We must reduce the availability of tobacco and alcohol to minors; and illicit drugs in Lincoln/Lancaster County; we must provide available and affordable treatment for anyone who needs it; and we must change public opinion from accepting substance abuse as a normal way of life to one that finds substance abuse unacceptable. To accomplish these goals funding will be sought, policies may be changed and issues of cost effectiveness and internal competency will remain priority considerations.

Three teams, Prevention, Treatment, and Criminal Justice, each developed a portion of the plan. Each team reviewed existing services and gaps in the service system; examined "Best Practices" which may be applicable for our community, and developed a set of principles within which to work.

The Prevention Team organized a Prevention Coalition and developed a Prevention Plan which A) is intended to be a proactive process using a multi sector approach; B) is based on six federal prevention strategies and a logic model of program development; C) addresses both adult and juvenile populations; and D) develops a continuum, beginning with a Community Readiness Analysis.

The Treatment Team recognizes the importance of its link to both prevention and criminal justice. The action plan recognizes Treatment as a part of a network of care where our primary gap is capacity limitations. It has based its action plan on seven Treatment and Recovery Milestones which address the major challenges impacting both juvenile and adult treatment needs.

The Criminal Justice Team recognizes that ever-increasing, full, and expensive prison cells cannot provide effective solutions to meet substance abuse problems in this community. Both criminal justice professionals and mental health and chemical dependancy professionals must better understand the nature and the goals of each other if they are to successfully treat the individual in the criminal justice system. Many of these individuals have multiple problems, including drug addiction. The Criminal Justice Team will develop strategies to better coordinate Substance Abuse Screening, Evaluations, and Treatment for the special population of criminal justice offenders.

Collectively these teams aim to reach our vision of a community free from substance abuse. We will utilize local baseline data developed through the Health People 2010 Plan as well as any achieved by the Community Readiness Survey. In three years, we firmly believe SAAT will have made a positive impact in Lincoln, Lancaster County, Nebraska.

Part I. Protective and Risk Factors for Substance Abuse

Risk and protective factors involve attitudes and behavior associated with the higher likelihood of use or of non use of substances. The role of risk and protective factors in social interaction and substance use has been investigated for about 20 years. The classification approach used by the majority of researchers combines factors into one of five domains: community, family, peer, individual, and school. Some research combines domains such as peer/individual, and others include a category of general or social climate as well.

Domain	**Risk Factor**	**Protective Factor**
Community	Availability of drugs (perceived & real) Laws and norms favorable to drug use Media portrayals of drug use in "exciting or attractive" ways. Community Disorganization Transitions and mobility Low neighborhood attachment Extreme social and economic depravation	Supportive networks and social bonds Opportunities for Pro-social involvement Rewards for pro-social involvement
Family	Lack of family involvement Poor family management practices Attitudes favorable to delinquency & drugs Low attachment Child Abuse	Attachment to parent/care giver Presence of rules and structure Sharing family responsibilities Religious faith and affiliations Care givers manage stress well
School	Academic Failure Poor performance in school Dropping our of school Low commitment to school Schools with multiple problems	Positive school experiences High educational expectations School structure/rules Attachment to teacher
Peers	Association with delinquent/drug using peers Lack of access/rejection from pro-social peers Gang involvement	Close friendships with pro-social peers
Individual	Rebelliousness Favorable attitudes to drug use Perceived risk of drug use Early and persistent antisocial behavior Sensation seeking Poor social problem solving skills Inability to understand others' perspective Poor conflict resolution skills Inability to understand moral consequences Impulsivity and other temperamental traits	Positive social orientation Positive temperamental characteristics Independent, self-help skills Good health Good reading skills problem-solving skills Achievement oriented Positive beliefs & attitudes Internal locus of control Educational

Our community (Lincoln/Lancaster County) has a number of qualities that contribute to the community domain aspects of protective and risk factors.

Protective Factors	**Risk Factors**
• Community Policing-neighborhood approach to law enforcement. • LLCHD involvement in Health People 2010 identifies Substance Abuse as a public health issue. • Community Coalitions growing attention to substance abuse issues and working together to address (NU Directions, CSIP, Substance Abuse Action Teams, Justice Council, Family Violence Council). • Lincoln Public School - investment in substance abuse curriculum as well as integration of prevention into health and other class areas. • Community Learning Centers meant to build community protective factors. • Responsible Hospitality Council - business community willingness to look at good business practice. • Youth serving organizations doing good things with youth and incorporating substance abuse prevention strategies into their programming (Lighthouse, YWCA, Indian Center, Cedars, Child Guidance, Big Brothers Big Sisters, Asian Center, Hispanic Center, YMCA, Scouts, Parks and Recreation, recreation centers throughout Lincoln). • Cultural Centers and New Americans Task Force address needs of ethnic and non-English speaking population.	• Growing criminal justice population with identified substance abuse problems (juvenile and adult). - Few community alternatives to incarceration that address substance abuse (Drug Court started in 2001). • Underemployment - low wages in Lincoln. • Numerous college/university campuses bring along with them issues of binge drinking, parties, "club drugs", and marijuana use. • Density of liquor licenses in downtown area. • Immigration and migrant workers increasing in numbers and often experiencing numerous stressful situations contributing to use of substances or don't have knowledge of legal issues and use of substances. (DUI/DWI) • Lack of affordable and accessible treatment options in community. • No community strategy to support prevention as a realistic approach to curtail substance use. • Lack of formalized cooperative/coordinated effort amongst government (local and state), human service, law enforcement, and health professionals (medical and public health) to address Substance Abuse as a priority Public Health Problem. (Only informal currently)

Part II

Evaluating Our Success
Baseline Data/Working Action Plan

While each of the three teams have developed their own goals, objectives and strategies, they all have the same common vision: to have a community free of substance abuse. To accomplish this vision it is important to recognize the baseline data which exists nationally and locally. National data comparison tells us where we are, compared to others in the country. Local data will give us our own way to measure success.

The three SAAT teams agree, three major goals need to be addressed if we are to begin to reach our vision.

1. We must reduce the availability of tobacco and alcohol to minors; and illicit drugs in Lincoln/Lancaster County.
2. We must provide available and affordable treatment for anyone who needs it.
3. We must change public opinion from accepting substance abuse as a normal way of life to one that finds substance abuse unacceptable.

Goal #1: To reduce the availability of tobacco, alcohol, and illicit drugs in Lincoln, Lancaster County.

National/State Data

A) 76 million people - including 11 million under age 18, have been exposed to alcoholism in their families.
B) Of the 105 million current users of alcohol, 45 million are binge drinkers and 12 million are heavy drinkers.
C) Nearly 1/3 of youth driving age drink. The leading cause of death among youth ages 15-20 is drunk driving.
D) Although it is illegal to sell and distribute tobacco products, youth under 18 can readily buy tobacco products.
E) Over 5 million high schoolers binge drink at least once a month.

Local Baseline Data:

A) The number of students grades 9-12, reporting self reported use of alcohol/drugs last 30 days.
B) The number of licensed liquor establishments in Lancaster County in year 2001.
C) The number of alcohol-related traffic fatalities involving youth under age 21.
D) The amount of money spent on advertising.
E) The amount of money United Way/JBC spends on Behavioral Health.
F) NU Directions Data

Analysis

Substance abuse is the number one health problem in America. Billions of dollar are spent marketing products. Billions more are spent in the health care system treating those who abuse those products. The more available alcohol and other drugs are in a community, the higher the risk that young people will abuse drugs in that community. Perceived availability of drugs is also associated with increased risk in Lincoln and Lancaster County.

Goal #2: To increase the amount of available affordable treatment to anyone who needs it.

National/State Data

A) Last year 50,000 clients were on state waiting lists for substance abuse treatment.
B) Only 14% of all women, and 12% of all pregnant women who need substance abuse treatment receive it.
C) The Child Welfare League of American reports 67% in the child abuse system in 1997 were in need of substance abuse treatment, and 31% actually received it.
D) In Nebraska, 65-80% of the juvenile population at Youth Residential Treatment Center need substance abuse treatment (as opposed to only 5% of the general youth population).
E) In Nebraska 65-85% of incarcerated adult offenders need substance abuse treatment compared to only 7% of the general population.
F) In Nebraska, substance abuse dollars for treatment have decreased 16.5% since 1992.

Local Baseline Data

G) The number of women on treatment facility waiting lists.
H) The amount of money spent on substance abuse treatment.
I) Number of substance abuse treatment beds available.
J) Number of licensed professionals available.
K) The number of clients served.
L) The number of persons incarcerated (Kearney, Geneva, Lancaster County Corrections, Lancaster County Juvenile Detention) identified needing substance abuse treatment; the number receiving it.
M) Number of people using detox center for substance abuse.

Analysis:

We enjoy the amount of money the sale of tobacco products and alcohol brings in, but we don't want to expend the money necessary to help those who have health problems as a result of its use and abuse. Treatment is often long term and expensive.

The State of Nebraska woefully under funds treatment of alcohol abuse. The number of beds available for youth are few; the number of affordable treatment beds for adults, virtually non existent. All existing services are at or above capacity. This gap in service will take more than local dollars to address.

Goal #3: To change the tide of public opinion from one of accepting substance abuse as a normal way of life to one which finds it unacceptable behavior.

Contrary to popular opinion, 75% of substance abusing men and women are married, live at home, hold a job, and are reasonable well accepted members of their community. State legislators are often social drinkers and sometimes abuse substances. Therefore, it is not unusual to see a hesitation in tightening laws which increase prosecution.

National/State Data

A) In 1998, the tobacco industry spent more than $6 Billion on advertising and marketing.
B) Drugs are perceived as a problem only when the sale and use of illicit drugs is highly visible. Nebraska is 2/3 rural and tends to see it as "other people's problem".
C) Of 4 million women who give birth each year in the U.S., 20% used illegal drugs, drink and smoke while pregnant.
D) For every person with substance abuse problems, at least four others are affected by their behavior.
E) The earlier a child begins drinking, the greater the odds he/she will become an alcoholic. Children drink 25% of all alcohol consumed in the United States.

Local Baseline Data

1. While there are several separate efforts to address public opinion regarding substance use/abuse, none are coordinated or long term.
2. Publication and promotion of the Community Readiness Survey Results.
3. Number of law enforcement arrests for illicit drugs.
4. Percentage of binge drinking as reported to the Behavioral Risk Survey and NU Directions.
5. Reported use by youth grades 9-12, over the past 30 days.

Analysis:

If the country agrees to spend even ½ the amount of money we spend on marketing and promoting tobacco products and alcohol, on multi-media to prevent substance abuse and change public attitude, the tide will change.

Locally, Lancaster County needs to take the lead. We need to identify how ready Lincoln is to move forward; find the funds; and implement a public education campaign to change public opinion. We need to view substance abuse as unacceptable behavior, not just for youth, but for the adults who are their role models.

Working Action Plan
"Evaluating Our Success as a Community"

Goal #1: (Availability) To reduce the availability of alcohol, tobacco, and illicit drugs in Lincoln, Lancaster County, Nebraska.

Baseline Data	Aim by 2005	Strategies
1. # of 9-12th graders self report drug use in last 30 days. 2. # of on sale liquor licenses issued in Lancaster County. 3. # of youth under 21, arrested for drunk driving. 4. # of off sale (liquor stores) in Lancaster County. 5. UNL NU Directions data .	1. To reduce usage by 10% within first 12 months. 2. To maintain # of licenses. 3. To reduce # of youth under 21 arrested for Drunk Driving by 10% the first year. 4. To maintain # of off sale stores in Lancaster County. 5. Use NU Directions data.	1. Develop a public education campaign targeting youth. 2. Evaluate policies and criteria used by Nebraska Liquor Control Commission. 3. Develop a coordinated response with law enforcement, MADD, LCAD, schools, and community businesses and agencies to focus on issue. 4. Work with local media companies and advertising firms to implement a local strategy for media advocacy. 5. Evaluate policies and procedures of City of Lincoln, Liquor Committee. 6. Continue to coordinate with the UNL Campus Substance Abuse Project.

Goal #2: (Treatment) to make treatment affordable and available to anyone who needs it.

Baseline Data	Aim by 2005	Strategies
1. # on waiting lists.	1. To reduce the waiting list by 15% after the first 12 months..	1. Volunteer to develop and apply for medicaid waiver on behalf of the state.
2. Amount of money spent on treatment.	2. To increase the available dollars in Lancaster County for treatment by 25% within the next 12 months.	2/3/5. Apply for Regional, National and Federal funding.
3. # of beds available.	3-5. To increase bed space, # of licensed professionals, and # of clients served by year end.	4. Hire Substance Abuse Evaluator in Juvenile Detention who will also work with parents in 3A court cases.
4. # of licensed-certified professionals available.	6. To establish outpatient treatment for adult offenders.	6. Implement community based alternatives to incarcerate recommended by 2002 County Corrections Master Plan.
5. # of clients served.	7/8. Insuring availability of needed services.	7/8. To identify and develop current gap areas and level of capacity needed.
6. # of incarcerated adults in need of treatment. # of juveniles.	9. Provide screening, evaluation and treatment opportunities for 3A parents.	9. Local resources work with Juvenile Court to implement process of screening evaluation, and treatment referral.
7. # of identified as "in need" who do not receive treatment.	10. To be able to make a longer term commitment to a multi-need, indigent client.	10. To increase overall public services to indigent clients.
8. # of people using detox services.	11. To reduce inappropriate, chronic repetitive use of our substance abuse service system.	11. Form a Task Force to ID "problem" users of system and make recommendations to reverse this use.
9. # of parents of child abuse cases, in need of treatment.		
10. # of services available for indigent clients.		
11. Need to define "misuse of services."		

Goal 3: (Public Opinion) To create a public attitude which finds substance abuse an unacceptable behavior.

Baseline Data

1. Current perception regarding substance use.
2. Lincoln Public Schools curriculum operational, and use of community resources.
3. Limited State Statutes on drunk driving, underage drinking and illegal sales to minors.
4. Enforcement efforts ie: checkpoints; compliance checks (alcohol & tobacco); party "patrol."
5. Random activities, individually successful.

Aim by 2005

1. Clear understanding of our target audiences.
2. Enhanced Lincoln Public Schools curriculum, and use of community resources.
3. Revise and Amend in Nebraska to have greater impact on the issues.
4. Increase enforcement efforts.
5. Coordinated calendar of activities created.

Strategies

SAAT Teams shall:

1. Conduct MIPH Community Survey to establish baseline,
2. Work with Lincoln Public Schools curriculum department and administration
3. Work with Mothers Against Drunk Driving to strengthen statutes where possible.
4. Support enforcement efforts of LPD and LSO and look for ways to bring attention to efforts successes.
5. SAAT forms Community Coalition to address marketing.

Part III

A. PREVENTION TEAM

1. Review of existing services and gaps.

The Prevention SAAT discussed prevention services currently offered in Lincoln/Lancaster. From this discussion it was clear that there is no comprehensive listing of substance abuse prevention programming in the community. The team decided that development of a "Prevention Matrix" would be useful. Information included in the matrix was identified by the Prevention SAAT members as follows: Age (prenatal through 55+ broken down into appropriate levels), gender specific (male/female/both), cultural specific, language specific, service area locations (would correspond to a map of the community to identify the area), Center for Substance Abuse Prevention strategy or strategies addressed, budget for service and where funding comes from, and cost to participant if any. Agencies, organizations, communities of faith, schools, and other possible program providers will be asked to complete the matrix to identify their prevention services. Much of what we hope to learn through the development of the matrix is what prevention resources we have, what strategies do they address, what populations they target, and reaffirm are they using "science based" programs, in order to evaluate their outcomes.

Development of trained "prevention professionals" has increased in Lincoln/Lancaster County over the past three years. Numerous agencies and organizations have sent staff through Prevention Generalist training offered through the state prevention system. The Lincoln Council on Alcoholism and Drugs has been training community agencies and organizations on the six federal strategies from substance abuse prevention identified by the Center for Substance Abuse Prevention. The six strategies are: Information Dissemination, Prevention Education, Alternatives, Problem Identification and Referral, Community Based Processes, and Environmental Approaches.

Promotion of "science based" prevention programming is also evident in the community with agencies incorporating numerous "Model" programs as identified by SAMHSA (Substance Abuse Mental Health Services Administration). Examples of these are the FAST (Families and Schools Together) program of Family Services and Lincoln Public Schools, Big Brother-Big Sisters mentoring program, Life Skills (currently being offered in a few Lincoln/Lancaster County schools and to the community through the Malone Center), Strengthening Families (LCAD and UNL Cooperative Extension), and a pilot project of Keep a Clear Mind (LCAD and Lincoln Public Schools). Additionally there are "science based" programs such as Head Start, TAP, HALO, CHAMPS, Media Literacy Project and others that are being implemented with increasing frequency throughout the community.

Increased prevention training, incorporating appropriately balanced strategies, and use of "science based" programs all indicate that our community is heading in the right direction. Promotion of these three areas (training, balanced strategies, and science based programming) throughout Lincoln/Lancaster County can grow a prevention effort that is effective and creates positive community change. Finally, community coordination should eliminate any potential fragmentation from occurring.

2. Prioritization of Service Gaps

The Prevention Team developed a format to identify prevention gaps for the community through the initial phases of our planning process. There are several essential assessment steps necessary in order for the Prevention Team to identify the gaps and then prioritize them. The Prevention Team proposes to assess the protective and risk factors for youth ages 10-17 by using the Communities That Care survey, take the prevention "temperature" of adults through use of the Minnesota Community Readiness Survey, obtain youth and adult input through Town Hall Meetings, and identify current prevention programs through a Service Matrix. Once these "assessment" functions have been finalized a process of identification of service gaps can proceed, and from that the development of action strategies to correct these deficiencies can be developed.

3. Philosophical Considerations

The following narrative is taken from the draft "State of Nebraska Blueprint for Building Communities" section entitled Guiding Principles and Philosophy.

Prevention is a proactive process of planning and service delivery that has as its ultimate goal healthy lifestyles for individuals and comminutes, freeing them of alcohol, tobacco, and other drug (ATOD) problems, including addiction problems. Substance abuse prevention activities have as their desired outcome:

1. Abstinence from illegal drug use.
2. Abstinence from harmful use of prescription and/or over the counter medications.
3. Abstinence rom alcohol/tobacco use by those individuals under the legal age.
4. Low risk alcohol use by the adult community.

Prevention services should use multiple approaches and should be community-based and cooperative, culturally and developmentally appropriate, carefully planned, flexible, tolerant of differences, accountable, capacity building, affordable and accessible, policy supported, empirically based, and adequately funded.

The following beliefs and commitments are the core of the Nebraska Prevention System's approach to its work.

The beliefs that...

- It is more effective in terms of human suffering and societal costs to prevent substance abuse rather than intervene or treat the problem at a later stage.
- Prevention is not a singular strategy or event but a complex comprehensive process that is based on the Center for Substance Abuse Prevention (CSAP) six strategies. It balances universal prevention strategies for the general population, with services designed for and delivered to specific and high-risk populations.
- Prevention of substance abuse is based on the understanding that the factors, which contribute to abuse, vary among individuals, age groups, rural, urban and suburban communities, ethnic groups, and risk level grouping. Specifically tailored prevention services must be made available for these diverse groups through a variety of providers and strategies.

- Youth are valued partners in community change. Youth involvement is necessary in all aspects of community attitude change and growth.
- Strength-based prevention efforts are necessary for all populations in every community.
- It is essential for prevention programs to be monitored to assure public safety, promote quality service delivery, and protect the integrity of public funds.
- The development of an effective prevention system requires coordination among public and private resources.
- Prevention is most effective when there is local understanding of the substance abuse problem and local responsibility for its prevention. Prevention programming must be locally based, with broad community involvement and with public sectors jointly sharing the responsibilities for services.
- Prevention planning should be based on an understanding of both risk and protective factors influencing alcohol, tobacco, and other drug use. Prevention activities should be conducted in partnership with target populations and emphasize their strengths.
- Substance abuse prevention professionals, in order to provide quality services, require core training in health education, community organizing, facilitation skills, alcohol, tobacco, and other drugs, substance abuse and addition, prevention strategies for impacting risk and protective factors, and professional ethics.

4. Best Practices

There are numerous nationally recognized resources that outline prevention "best practices" and also identify promising strategies for addressing substance abuse. Among these are the National Institute on Drug Abuse research-based guide entitled "Drug Use Among Children and Adolescents" as well as the Center for Substance Abuse Series "Guide to Science-Based Practice" 1, 2 and 3.

Among the principles that are offered in these documents are the following:

1. Prevention programs should be designed to enhance "protective factors" and move toward reversing or reducing known "risk factors"
2. Prevention programs should target all forms of drug abuse, including the use of tobacco, alcohol, marijuana, and inhalants.
3. Prevention programs should include skills to resist drugs when offered, strengthen personal commitments against drug use, and increase social competency, in conjunction with reinforcement of attitudes against drug use.
4. Prevention programs for adolescents should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques only.
5. Prevention programs should include parents' or care giver's component that reinforces what the children are learning - such as facts about drugs and their harmful effects - and that opens opportunities for family discussion about use of legal and illegal substances and family policies about their use.
6. Prevention programs should be long-term, over the school career with repeat interventions to reinforce the original prevention goals. For example, school-based efforts directed at elementary and middle school students should include booster sessions to help with critical transitions from middle to high school.

7. Family focused prevention efforts have a greater impact than strategies that focus on parents only or children only.
8. Community programs that include media campaigns and policy changes, such as new regulations that restrict access to alcohol, tobacco, or other drugs, are more effective when they are accompanied by school and family interventions.
9. Schools offer opportunities to reach all populations and also serve as important settings for specific sub-populations at risk for drug abuse, such as children with behavior problems or learning disabilities and those who are potential dropouts.
10. Prevention programs should be adapted to address the specific nature of the drug abuse problem in the local community.
11. The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.
12. Prevention programs should be age-specific, developmentally appropriate and culturally sensitive.
13. Effective prevention programs are cost-effect. **For every dollar spent on drug use prevention, communities can save 4 to 5 dollars in costs for drug abuse treatment and counseling.**

In addition to those principles mentioned above CSAP offers communities a methodology to address the very complex problem of substance use. Substance use develops in response to multiple influences. These spheres of activity, typically called domains, include the individual, family peers, school, community, and society/environment. Characteristics and conditions that exist within each domain of activity also function as risk or protective factors that help propel individuals to or safeguard them fro substance abuse. As such each of these domains presents an opportunity for preventive action. The CSAP Guide to Science Based Practices breaks down each of these domains and has identified scientifically defensible principles that can help service providers design and implement programs that work.

It is imperative that Lincoln/Lancaster County addresses substance abuse from a strategy that balances domains and does not solely concentrate in one domain versus another. No one strategy or attention to a domain can solve this challenging problem. Working together with the treatment community, criminal justice, the public health and medical sectors of our community are essential.

In February 2001 the Robert Wood Johnson Foundation published the report "Substance Abuse - The Nations's Number One Health Problem". This report states "Prevention and treatment strategies are increasingly effective when applied to reduce substance abuse and its effects on the nation." "As we begin a new century, many problems relating to substance abuse need to be solved. Illicit drugs are still widely available, and tobacco and alcohol continue to be easily accessible to underage youth; rates of use and experimentation by youth are on the rise for some substances; and while there are effective prevention and treatment programs, they are underused and not broadly available."

5. Planning for Substance Abuse Prevention

PROBLEM STATEMENT: The City of Lincoln and Lancaster County currently lacks a comprehensive and coordinated substance abuse prevention effort.

Recommendation #1: Develop a "Prevention Plan" for the community.

I. Elements of the Plan
   A. Assess need for substance abuse prevention services.
      1. Community Readiness Survey (Spring 2002)
      2. Communities that Care Survey (Fall 2002) (Fall 2003) (Fall 2004) - Lincoln Public Schools & Rural School Districts
      3. Town Hall meetings (Spring-Summer 2002)
      4. Archival Data (LLCHD YRBS and BRS, LPD and LSO) Spring/Summer 2002.
   B. Existing Services
      1. Matrix disseminated to agencies and organizations throughout the community. (Spring/Summer2002)
   C. Prevention SAAT Team identifies "gaps" in services using information from the assessment process and cataloging of existing services. (Winter 2002/03)
   D. Development of action strategies for the Prevention Plan to address issues identified in the assessment and service matrix phases. (Spring 2003).
   E. Implementation of Prevention Plan (Summer 2003)
      1. Evaluation of Plan built into plan from beginning.

Recommendation #2: Organize a "Prevention Coalition" for the community.

I. Coalition Development (ongoing from Prevention SAAT establishment)
   A. Identify potential members -
      1. Prevention Policy Board
      2. Other coalition members (Teen Pregnancy Prevention, Asset Coalition, Behavioral Health Coalition of CSIP)
      3. Youth membership
      4. Other members to meet requirements of federal guidelines for Community Coalition?
   B. Identify meeting frequency, place, and time.
   C. Identify structure of coalition (officers, procedural mechanisms, etc.)
   D. Identify strategies to "grow" the coalition and move forward with support of prevention planning efforts. "Strategies Planning" process.

Recommendation #3: Integrate the Prevention Plan with Treatment and Criminal Justice Teams

I. Identify strategies of the Prevention Plan that benefit the other teams and vice versa.
II. Leverage community efforts as an integrated approach to the problem - communication strategies, policy changes, etc., are approached from all three teams speaking as one voice.

B. TREATMENT TEAM

1. Review of existing services and gaps.

The Treatment Team reviewed treatment services currently offered in Lincoln/Lancaster County. At first glance, it appears we are rich in resources. What we need to further examine are the actual number of beds available and how many persons appear on a waiting list. Waiting lists do not tell you how many people have given up waiting and moved on. Current services include.

1. Existing Services include:

Medical Detox/Inpatient
Social Detox
Medically Monitored Inpatient
Intermediate Residential (adult males)
Short-Term Residential
Short-Term Residential: Mother/Child
Dual Disorder Long-Term Residential
Partial Care/Day Treatment
Intensive Outpatient
Outpatient
Continuing Care/Aftercare
Treatment Group Home (girls only)
Therapeutic Community (women's only)
½ way House (men only)
Professional Partners/Wrap-A-Round
Community Support
Case Management
Alcohol & Education
School/Community Intervention Program (SCIP)
Substance Abuse Evaluations
Prevention

Current Gaps in Service Include:

Emergency Services
Intermediate Residential (women & adolescents)
Treatment Group Home (boys)
½ way house (women)
3/4 way house (men & women)
Pre-treatment services
Any services to non-English speaking population
Any services to the deaf or hard of hearing

2. Prioritization of Service Gaps

The primary gap in the services available in Lancaster County involved the reality that the services that are identified as "existing" are at or above capacity. Our primary gap is capacity limitations!! Lancaster County has done a fairly good job making available a semi-complete continuum of care but has not done well in prioritizing the capacity that certain levels of care are able to accommodate. The lack of funding options and low reimbursement rates has made the expansion of needed services impossible. The gaps identified would round out what we would consider a complete continuum of care.

We need to be committed to raising funds to complete the continuum of care. In addition, we need to examine changes in that continuum, which may be more affordable, timely, and provide long-term effectiveness. This may involve expanding our vision beyond simply the need for more beds.

3. Philosophical Considerations

Substance abuse treatment, when made available and affordable, can drastically impact the overall cost of healthcare. Many national studies have shown the effectiveness of substance abuse treatment on reducing costs associated with other medical care. Despite this, there continues to be a lack of awareness regarding the tremendous cost savings to universal healthcare and a general lack of understanding and funding allocated to treat this problem. Chemical dependency treatment, (not unlike the treatment of diabetes and heart disease) requires proper identification, various levels of treatment over time, and lifelong follow-up in order to be effective. In addition, pre-treatment and post-treatment levels of care options are paramount to recovery, but are also the least likely to be funded adequately.

4. "Demand Treatment" Efforts Nationally

Boston University School of Public Health conducts a project called "Join Together." It is an online sharing of Best Practices programs and lessons learned. There are 15 local partners of the "Demand Treatment" grant project who share their success stories as well as what did not work. Best Practices which may be relevant for Lincoln/Lancaster county to consider include:

1) Substance Abuse screenings and brief intervention programs are conducted at local hospitals for both emergency room clients and pregnant women (prenatal through birth), (Denver, Colorado, Trenton, New Jersey).

2) Friends of Recovery is created to implement a marketing campaign to deliver effective treatment program promotion messages, advocate recovery information and support an encourage recovery. (Manchester, New Jersey)

3) "One Stop Shop" is a resource center which offers resources in: prevention education, medical care, social and law enforcement resources, screening and assessments. (Boise, Idaho)

4) Website technology can be used for self evaluation, program recognition and referral. (Denver Colorado)

5) Development of a Comprehensive, bipartisan supported parity legislation for substance abuse addiction. (Vermont, Arizona)

The concept of "demanding treatment" and coordinating "Friends of Recovery" to drive change and encourage personal successes are outstanding concepts found to be successful in other states and can work here.

6. Action Plan/Recommendations (Year one)

Recommendation #1: Involve Substance Abuse Providers in Lancaster County in research and development of the countywide treatment plan.

Action Steps:

1. Research and review other county plans across the country.

2. Gain "Buy in" of substance abuse providers by mailing personal contact invitations.

3. Review best practices and prioritize.

Recommendation #2: Create greater awareness and acceptance for Lincoln/Lancaster County Substance Abuse Treatment needs.

Action Steps:

1. Develop "Treatment and Recovery Milestones" to enable providers to focus on common goals even though they may have different approaches.
2. Begin tracking Juvenile Assessment Center's substance abuse evaluations.
3. Form a core of medical personnel (physicians, ER nurses, gynecologist) to address the awareness role of local hospitals, clinics, and doctor's offices in screening and referral of substance abuse.
4. Work with Prevention Team on recruiting a "Friends of Recovery" campaign to deliver effective program promotion messages.
5. Work with Adult Criminal Justice Systems to ensure sound treatment practices connected to criminalgenic needs for those who are in the criminal justice system.

Recommendation #3: Continue to encourage the State of Nebraska to use existing resources ($17,500,000) more effectively and to seek federal revenue for substance abuse treatment, as well as parity for insurance coverage.

Action Steps:

1. Seek RW Johnson and SAMSHA substance abuse funding for treatment expansion.
2. Continue to seek Crime Commission dollars for juvenile substance abuse.
3. Support increase in alcohol excise tax to be earmarked for substance abuse prevention and treatment.
4. Work to address "parity" as a local and statewide next step to supporting services.

C. CRIMINAL JUSTICE TEAM

PROBLEM: Currently Lancaster County does not coordinate, fund or provide appropriate substance abuse screening, evaluations and treatment for special populations of the criminal justice system.

1. Background Information

For many years, Lancaster County has had an informal, under-funded, working relationship between the substance abuse treatment community and criminal justice. Cooperation has existed as the result of the size of Lincoln as well as the good-will effort of both systems to work together.

As Lancaster County has grown, so has the need for substance abuse treatment within Criminal Justice. As the need for substance abuse treatment has grown, so have the waiting lists for treatment providers and the challenges of the two systems to work cooperatively.

Historically, publicly funded providers have been "governed" by standards and certification practices that come from the Nebraska Department of Health and Human Services as well as the Regional System. In the case of Lancaster County that has been Region V Systems. Locally, Region V has always allowed clients who are involved in the criminal justice system to be treated just like any other eligible client. There have not been any specialized treatment services for criminal justice clients through Region V until this year (2001-2002) with the authorization for funding for Adult Drug Court clients. The State Department of Corrections has not made local funding available to address community based treatment and alternatives to incarceration. Funding for all persons in need of substance abuse treatment is inadequate to meet the needs of our community and so in turn the criminal justice sub-population is negatively effected as well.

The results of the growing criminal justice demands on the local substance abuse treatment system are of concern to both criminal justice and treatment providers. Treatment providers want to provide services to people in need. However, they are now being asked to treat criminal justice clients sometimes without knowing what special needs they might have or what best practices are known about treating this particular population. Cooperative educational opportunities between the two systems have only recently been available on a local basis (Domestic Violence and Substance Abuse trainings in 2000 and 2001). In addition, the growing number of referrals from criminal justice is impacting the waiting lists of providers. When criminal justice clients are put on waiting lists, that often means they are not meeting probation requirements or other court ordered sanctions.

What we are currently experiencing is a growing demand, coupled with inadequate funding, thereby resulting in a rehabilitative model that is unable to rehabilitate. The mutual interests of the Criminal Justice and Treatment community are best served by a coordinated effort that addresses capacity building, training, and ongoing communication.

2. Implementation Plan for Year 1 (first 12 months)

Recommendation #1: Incorporate the following plans within the criminal justice piece of the community Comprehensive Substance Abuse Plan

Action Steps:
- 1a: Lancaster County Juvenile Plan
- 1b: Lancaster County Corrections Plan
- 1c: Governor's Task Force Plan

Recommendation #2: Define the population within the Criminal Justice System

Action Steps:
- 2a: Lancaster County Corrections Data
- 2b: Lancaster County Adult Probation Data
- 2c: Lincoln Police Department Data
- 2d: Lancaster County Sheriff's Department Data
- 2e: University of Nebraska Lincoln Data
- 2f: Lancaster County Drug Court Data
- 2g: Cornhusker Detox Data
- 2h: Juvenile Justice System Data
- 2i: Family Violence Council Data

Recommendation #3: Track the population within criminal justice

Action Steps:
- 3a: How many people are being referred from criminal justice for treatment?
- 3b: How many people cannot access treatment as the result of waiting lists?
- 3c: How many people cannot access treatment because the services are not there?
- 3d: What substances are being abused?

Recommendation #4: Integration of criminal justice with prevention and treatment

Action Steps:
- 4a: Linkages
- 4b: Funding Streams
- 4c: Drug Courts
- 4d: Justice Council
- 4e: Region V
- 4f: Crime Commission

3. Recommendations for years 2 and 3

Recommendation #1: Continue identifying Criminal Justice Population

Recommendation #2: Continue tracking of Criminal Justice Offenders within the treatment system.

Recommendation #3: Continued Integration of Criminal Justice with prevention and treatment

Recommendation #4: Legislative change (sentences match treatment)

Recommendation #5: Integration with Mental Health and other Behavior Health Systems.

Recommendation #6: County/City staff person to coordinate Criminal/Justice System and Behavioral Health System

4. Current Criminal Justice Projects

During the first year, the Youth Assessment Center will hire staff to conduct juveniles with substance abuse issues. They will also use these contract staff position(s) to evaluate parents of 3A child abuse cases when directed by the court. It will also be in our best interest to be involved with implementation of the Voorhees study advocating for day treatment centers available so persons can access treatment in a timely and affordable manner. Integration of the criminal justice system with prevention and treatment will be successful, only when funds are willing to be shared, professionals are willing to be cross-trained, and all parts of the system are held accountable for contributing to the collective positive or negative result.

PART IV: Closing Observations and Evaluation

By year 2005, Lincoln/Lancaster County, Nebraska will have mobilized schools, families, media, business, and government with an extensive network of collaborating organizations to work toward a common vision of a drug-free community. Specifically, we will maintain effective task forces on prevention, treatment and criminal justice which will have:

1. Conducted a community readiness analysis of Lincoln, Lancaster County;
2. Increased awareness and acceptance of substance abuse as a serious public health issue;
3. Established an expanded comprehensive continuum of care with integrated treatment throughout the community, including specialized treatment;
4. Developed a prevention campaign advocating for a change in public attitude.
5. Reviewed and continue to monitor public policies at all levels of their development.
6. Integrated the criminal justice system with prevention and treatment systems.
7. Integrated substance abuse with other issues in the Behavioral Health for a seamless system of care.

The SAAT will continue to operate with the steering committee's guidance under the Justice Council and in collaboration with CSIP; Behavioral Health Subcommittee. Benchmarks will be monitored in two areas. The Prevention, Treatment and Criminal Justice Council teams have or will be setting measurable objectives to accomplish. In addition, overall community benchmarks will be a part of the CSIP monitoring process and will be included in the broader Human Services report.

Glossary of Terms ATTACHMENT (1)

ATOD: An acronym for alcohol, tobacco and other drugs.

Baseline: A level of behavior or the score on a test that is recorded before an intervention is provided.

Behavioral Health: Care which provides presenting, intervention and treatment services in areas of mental health, substance abuse, developmental disabilities, and sexual health.

CASA: National Center on Addiction and Substance Abuse; Columbia University

Coalition: A diverse organization which agrees to work together in order to achieve a common goal, using human and material resources to bring about a change to benefit the community.

Criminal Justice Systems: Refers to both the Juvenile Justice System as well as the Adult Systems as they operate in this jurisdictions.

CSAP: Center for Substance Abuse Prevention

CSIP: Community Services Implementation Plan - the community wide human services initiative in seven key areas, including behavioral health.

Justice Council: An entity composed of the heads of all Criminal Justice related departments in local government. Purpose is to educate, advocate, and network within the system to address current ongoing needs.

Prevention: A proactive process of planning and service delivery that creates conditions & personal attributes that promote the well being of people.

Protective Factors: Those factors that increase an individual's ability to resist the use and abuse of drugs, e.g., strong family bonds, external support system, and problem-solving skills.

Risk Factors: Those factors that increase an individual's vulnerability to drug use and abuse, e.g., academic failure, negative social influences, and favorable parental or peer attitudes toward or involvement with drugs or alcohol.

SAAT: Substance Abuse Action Teams, which will implement strategies in prevention, treatment, and criminal justice over the next three years.

Substance Abuse: During the early stages of the comprehensive substance abuse planning process we determined a vision a healthy community. We agree "**We share the desire to have a community free from substance abuse. A vision of reality is to have a community where strong prevention measures prevail and where all people have access to substance abuse treatment."** We developed a working definition for substance abuse: **"Substance abuse will include alcohol, prescribed drugs, street drugs, and gateway drugs such as tobacco, whose use can have an intended or unintended negative impact on an individual or family life."**

Target Population: The SAAT plans address all ages from birth through adulthood.

Treatment: A program or set of services designed to get addicts off drugs and create permanent behavior change.

ATTACHMENT (4)

Substance Abuse Action Teams

Steering Committee:

Sheryl Shrepf, Families First and Foremost
Deb Sprague, Lincoln Council on Alcoholism and Drugs
Steve Rowaldt, Chief of Probation
Jerome Barry, Independence Center/Bryan LGH
Mary Barry-Magsamen, St. Monica's
Topher Hanson, Centerpointe
Kit Boesch, Human Services Administrator
Jay Conrad, Houses of Hope, Inc.
Kay Bursheim, Indian Center, Inc.

The following individuals have made a commitment to continue to serve on a SAAT team to implementation strategies for change:

Prevention Team

Chair: Sandy Morrissey, Lincoln Council on Alcohol and Drugs
Jerry Buss, Malone Community Center
Dennis Banks, Juvenile Detention Center
Chief Tom Casady, Lincoln Police Department
Kay Bursheim, Lincoln Indian Center
Becky Wild, Lincoln Public Schools
Emilia Gonzalez-Clements, Hispanic Community Center
Susan Scott, YWCA
John McQuinn, City Attorney's Office
Reverend Donald Coleman, MAD DADS
Deb Sprague, Lincoln Council on Alcoholism and Drugs
Sandra Miller, Cedars Youth Services
Sara Wolter, Lincoln Medical Education Foundation
Bonnie Coffey, Lincoln/Lancaster County Women's Commission
Jennifer Stuhmer, MAD DADS
Pam Loewenstein, Lincoln Action Program/Cedars
Shelly Main, Lincoln Action Program
Nicky Turner, Lincoln/Lancaster County Health Department
DeAnn Hughes, Public Policy Center UNL
CJ Johnson, Region V Systems
Don Siffring, Lincoln/Lancaster County Health Department
LeTroy Jones, Cedars Youth Services
Tom Crew, Big Bothers/Big Sisters
Mary Christensen, Lincoln/Lancaster County Health Department
Jacque Riese, Good Neighbor Center
Bill Jarret, Lancaster County Sheriff's Office
Sheila Kadoi, YWCA
T.J. McDowell, Lighthouse/Ordained Minister
Petra Smith, Cedars Youth Services
Gary Lacey, Lancaster County Attorney

Betsy Kosier, Mediation Center
Terry Wagner, Lancaster County Sheriff
Merry Wills, Freeway Station
Julie Cervantes-Salomons, Big Brothers/Big Sisters
LaDeane Jha, Cooperative Extension
LeeAnn Pancharoen, Lincoln Action Program
Kate Speck, Lincoln Medical Education Foundation-School & Community Intervention Program

Criminal Justice Team

Co Chairs - Steve Rowaldt Chief of Probation
Deb Sprague, Lincoln Council on Alcoholism and Drugs
Doug Graham, Centerpointe
Kelly Guenzel Handlos, Clerk of the District Court
Wendell Roscoe, Regional Center - Adolescent Services
Terry Weber, Lancaster County Corrections
DeAnn Hughes, Public Policy Center-UNL
CJ Johnson, Region V Systems
Julie Hippen, Lutheran Family Services
Jim Baird, Cornhusker Place, Inc.

Treatment Team:

Co Chairs - Jerome Barry, Independence Center/Bryan LGH
Mary Barry Magsamen, St. Monica's
Topher Hansen, Centerpointe
Julie Hippen, Lutheran Family Services
James Baird, Cornhusker Place, Inc.
Henry Moss, Families First and Foremost
DeAnn Hughes, Public Policy Center-UNL
CJ Johnson, Region V Systems
Trish Blakely, Healthy Families Project-F³
Suzy Meyer-Page, Child Guidance Center
Kate Speck, Lincoln Medical Education Foundation
Roy Schoen, Lincoln Vet Center
Deb Shoemaker, Lincoln Community Foundation
Melanie Gabbert, Cedars Youth Services
Maria Lavicky, Health and Human Services
Jay Conrad, Houses of Hope
Joyce Faddis, VA Medical Center-Mental Health Services
Deb Sprague, Lincoln Council on Alcoholism and Drugs

ATTACHMENT (5)

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